(3) (4) (3)

Nos. 93-1408, 93-1414, 93-1415

IN THE

Supreme Court of the United States

October Term, 1993

MARIO M. CUOMO, in his official Capacity as Governor of the State of New York; MARK CHASSIN, M.D., in his Official Capacity as Commissioner of Health of the State of New York; SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York; MARY JO BANE, in her Official Capacity as Commissioner of Social Services of the State of New York; and ROBERT ABRAMS, in his Official Capacity as Attorney General of the State of New York; NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD; and HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioners,

against

THE TRAVELERS INSURANCE COMPANY, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE and HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Respondents.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION TO PETITIONS FOR A WRIT OF CERTIORARI

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Dated: April 8, 1994

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32 pp

Counterstatement of Question Presented

Whether the Second Circuit Court of Appeals correctly held that section 2807-c (2-a) of New York's Public Health Law, which increases the cost of health care coverage provided by a health maintenance organization ("HMO") to an employee benefit plan if the HMO is unable to enroll a targeted number of Medicaid recipients, is preempted by ERISA?

Supreme Court Rule 29.1 Statement

Pursuant to Supreme Court Rule 29.1, the respondents listed below have the following parent companies and subsidiaries (except wholly owned subsidiaries):

Oxford Health Plans (NY), Inc.
PARENT COMPANY: Oxford Health Plans, Inc.

Physicians Health Services of New York, Inc.
PARENT COMPANY: Physicians Health Services, Inc.

Preferred Care
PARENT COMPANY: Preferred Care Holding Co.

Travelers Health Network of New York, Inc.
PARENT COMPANIES: Travelers Health Network, Inc.;
Travelers Health Co., Inc.;
Travelers Employee Benefits Co., Inc.;
Travelers Insurance Co.;
The Travelers Inc. (formerly Primerica Corp., successor to The Travelers Corp.);
Associated Madison Companies, Inc.;
and
The Travelers Insurance Group, Inc.

U.S. Healthcare, Inc.
PARENT COMPANY: U.S. Healthcare, Inc.

Wellcare of New York
PARENT COMPANY: Wellcare Management Group, Inc.

The remainder of the respondents do not have any parent companies or subsidiaries, other than wholly owned subsidiaries.

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Nos. 93-1408, 93-1414, 93-1415

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993.

MARIO M. CUOMO, in his Official Capacity as Governor of the State of New York, *et al.*,

Petitioners,

against

THE TRAVELERS INSURANCE COMPANY, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE and HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Respondents.

Brief in Opposition to Petitions for a Writ of Certiorari

Counterstatement of the Case

Preliminary Statement

This brief is submitted on behalf of the respondents New York State Health Maintenance Organization Conference and twelve health maintenance organizations (collectively referred to as the "HMOs")[1] in opposition to the petitions for a writ of certiorari of Mario M. Cuomo *et al.* (collectively referred to herein as "the State"), New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield (collectively referred to herein as "the Blues") and the Hospital Association of New York State (referred to herein as "HANYS"). Petitioners seek review of a judgment of the United States Court of Appeals for the Second Circuit that affirmed the District Court's February 3, 1993 Opinion and Order of Judge Louis Freeh. Judge Freeh held, *inter alia*, that the Employee Retirement Income Security Act of 1974, 29 U.S.C.A. §§ 1001 *et seq.* (West 1985 & Supp. 1992) (hereinafter "ERISA"), preempts Section 2807-c (2-a) of the New York Public Health Law, which imposes a penalty, calculated at 9% of the HMOs' aggregate cost of hospitalization, on HMOs that fail to enroll a specified number of Medicaid patients.[2]

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[1]The twelve HMOs are Health Services Medical Corporation of Central New York, Inc., MVP Health Plan, Inc., Wellcare of New York, Inc., Mid-Hudson Health Plan, Inc., Oxford Health Plans (NY), Inc., Capital District Physicians' Health Plan, Inc., ChoiceCare Long Island, Inc., Independent Health Association, Inc., Travelers Health Network of New York, Inc. Physicians Health Services of New York, Inc., Preferred Care, Inc. and U.S. Healthcare, Inc.

[2]Although the disputed statute imposes surcharges of 9, 11 and 13%, the HMOs are subjected only to the 9% assessment and this brief only addresses preemption of that assessment.

Although petitioners attempt to drape their arguments equally over the 9%, 11% and 13% assessments, there are critical differences between the 9% assessment levied on HMOs and the 11% and 13% surcharges imposed on commercial insurers. Similarly, petitioners gloss over the significant differences between HMOs, which actually provide care, and fee-for-service indemnity insurance companies. These differences make petitioners' arguments in favor of certiorari not only unpersuasive but also largely irrelevant as applied to the 9% assessment.

HMOs And Their Role In New York's Health Care System

The New York State Health Maintenance Organization Conference is a not-for-profit corporation consisting of 27 health maintenance organizations licensed to operate in and located throughout New York State. The HMOs in the Conference currently provide health care to more than three million people in New York.

HMO coverage differs from traditional health insurance. By combining the provision and financing of comprehensive health care, including primary and specialty physician care, with inpatient hospitalization, HMOs are able to provide quality health care in a cost efficient manner. HMOs accomplish this through a variety of contractual arrangements with doctors, other providers and hospitals.[3]

Unlike commercial insurance companies and the Blue Cross/Blue Shield indemnity insurance plans, HMOs serve

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[3]For example, some HMOs (group and staff models) employ their own physicians. Other HMOs (individual practice associations) use networks of physicians who agree to serve the HMO's subscribers and to adhere to the HMO's practice and payment guidelines.

Medicaid recipients. Under the State's Medicaid managed care program, HMOs enroll Medicaid recipients into their provider networks and receive a fixed monthly rate for each individual. HMOs also ensure that Medicaid recipients and their families have a primary physician to monitor their care on a regular basis. The use of a primary care physician and the availability of a health care network provide Medicaid recipients with better access to primary and preventive care than otherwise available under the traditional fee-for-service system and helps reduce costly emergency room visits. (JA 1550, ¶ 10)[4].

HMOs And Employee Benefit Plans

HMOs are required by state and federal law to offer a comprehensive health benefits package. 42 C.F.R. § 417 (1992); N.Y. Pub. Health Law § 4403 (McKinney 1985); N.Y. Comp. Codes R. & Regs. tit. 10, § 98.6 (1992). Because of the State's regulatory requirements, HMOs may not revise their benefits packages at will and may not reduce their core package beyond a certain level of benefits.

Under state law, employers generally are required to offer HMOs as a health benefit option to their employees. N.Y. Pub. Health Law § 4407 (McKinney 1985); N.Y. Comp. Codes R. & Regs. tit. 10, § 98.15 (1992). Most HMO contracts are with employee benefit plans.

When an employee benefit plan contracts with an HMO, the employees and their dependents must each select a primary care physician who has the responsibility to over-

[4]"(A—)" refers to the Appendix filed by Petitioners herein. "(JA—)" refers to the Joint Appendix filed in the Court of Appeals. "(R—)" refers to the Record on Appeal in the Court of Appeals.

see and coordinate the care that is provided. By designating a single physician to coordinate care, there is one individual who knows the medical history and needs of each employee and the employee's family. In most cases, members must receive the approval of the primary care physician before seeing a specialist. HMOs also work closely with their members prior to and during hospitalization to ensure that there is adequate preparatory work and to minimize the length of the hospital stay. (JA 1551, ¶¶ 13, 14).

As noted above, in some cases the HMO's physicians are salaried employees of the HMO and are principally available only to serve the members of the HMO. Thus, if an employee benefit plan terminates its contract with such an HMO and switches to a different type of health care coverage, the employees and their families would not be able to continue to use the physicians who they have been using and who are most familiar with their medical history. (JA 1551, ¶ 15).

The New York Statute

Generally speaking, inpatient hospital care in New York is reimbursed on a case-based system, rather than on the charges that the hospital might otherwise impose. Upon entering a hospital, a patient is placed into a category known as a diagnosis-related group ("DRG") based on the patient's condition. The patient is then billed for the rate assigned to the appropriate DRG rather than for the actual cost of treatment incurred.

Since the inception of DRGs in 1988, the DRG rate has been increased by 13% for patients covered by commercial insurance or self-insured plans. N.Y. Pub. Health Law

§ 2807-c(1)(b) (McKinney 1993). The 13% surcharge is added to the patient's DRG rate, billed by the hospital and paid by the patient or insurer directly to the hospital. The revenue generated by the 13% surcharge is retained by the hospital.

On April 2, 1992, New York State adopted the Omnibus Revenue Act of 1992 (the "statute") which amended the Public Health Law to impose (1) an additional 11% surcharge on the DRG rates of patients insured by commercial insurers; and (2) a penalty calculated at 9% of an HMO's aggregate cost of hospital care payable to the State by HMOs that fail to enroll a target number of Medicaid recipients.

Like the 13% surcharge, the 11% surcharge is added to the patient's hospital bill and paid directly to the hospital. The funds generated by the 11% surcharge are forwarded by the hospital to a pool established by the Commissioner of Health and then deposited into the State's General Fund.

The 9% assessment applies only to HMOs and directly affects the employee benefit plans that HMOs serve. The statute imposes a penalty, payable to the State and calculated at 9% of an HMO's aggregate cost of inpatient hospital care, on HMOs that are unable to attain certain Medicaid enrollment objectives set by the State. The 9% assessment is not an increase in the actual DRG rates that HMOs pay hospitals. Rather, it is a separate charge that is based on the aggregate monthly cost of the inpatient hospitalization that is paid by the HMO. In effect, the HMO calculates the cost of its inpatient hospitalization, multiplies the total by 9% and pays this amount into a statewide pool. The funds are then deposited by a State-designated pool administrator into the State's

General Fund. The funds are never paid to the hospital providing the service.

Under the statute, an HMO can reduce or eliminate the 9% assessment if the HMO achieves certain Medicaid enrollment objectives. An HMO can eliminate the 9% assessment if the HMO (1) has Medicaid contracts with every county in which it operates and (2) enrolls a defined target number of Medicaid recipients. Thus, unlike the 13% and 11% differentials, the 9% assessment can be reduced or eliminated if the HMO achieves the State's objective of enrolling a sufficient number of Medicaid enrollees into the HMO's managed care network.

The 9% assessment at issue also differs sharply from the 13% differential and 11% surcharge because the 9% assessment is not an increase in the rate of payment to hospitals. The rate an HMO pays a hospital is unaffected by the 9% assessment, and the 9% assessment produces no revenue for hospitals.

The 9% assessment is not an attempt to regulate either the hospital reimbursement system or the insurance system. Rather, the primary purpose of the 9% assessment is to encourage HMOs to enroll Medicaid patients (JA 482, ¶ 27). A secondary purpose is to raise revenue for the State.

The 9% Assessment Has a Substantial Economic Impact on Employee Benefit Plans

Although HMOs can reduce or eliminate the 9% assessment if they fulfill the State's Medicaid objectives, it has been exceedingly difficult for some HMOs to do so. Indeed,

for any HMO that did not already have Medicaid contracts in place and a substantial enrollment at the time the statute was enacted, it was virtually impossible to satisfy the requirements for eliminating the assessment in 1992. (JA 15, ¶ 21). Only ten HMOs qualified either for an elimination or reduction of the 9% assessment for the 1992 rate period. (JA 761, ¶ 15).

Moreover, while some HMOs were able to eliminate or reduce the 9% surcharge for the 1992 year, (JA 761, ¶ 15), there is no assurance that they will continue to be able to do so because the enrollment target increases in succeeding years. In addition, because there is no corresponding mandate on Medicaid recipients to enroll in an HMO, some HMOs with sufficient enrollment in one year may lack the requisite enrollment in the next year and thereby become subject to the 9% surcharge. (JA 1553, ¶ 21). As the district court recognized, "HMOs which do not or cannot meet the statutory requirements must pay the full amount." (A 22).

The assessment has had an immediate and dramatic effect on the rates that HMOs charge their subscribers, including employee benefit plans. Because the cost of hospitalization accounts for approximately 40% of the overall costs of an HMO, the 9% surcharge translated into an immediate increase of up to 3.5% in total costs for most HMOs. (JA 1553, ¶ 22).

HMOs cannot absorb this increase. (JA 1554, ¶ 23). Many HMOs are not-for-profit, including seven of the respondent HMOs. Some HMOs do not have large financial reserves and cannot absorb major and unexpected costs such as the cost of the 9% assessment. They cannot use reserves to fund these increased costs because, in the rate setting

process, the State has placed limits on the size of an HMO's reserves and, more importantly, because the reserves must be retained in the event that an HMO experiences unusually heavy medical claims. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.11 (1992).

The impact of the 9% assessment has been substantial. For example, for the period July 1, 1992 through December 31, 1992, Independent Health of Western New York was required to pay approximately $2.5 million and MVP Health Plan was required to pay approximately $1.5 million as a result of the assessment. In the face of such substantial charges, the HMOs have had no recourse but to request rate increases in order to transfer the cost of the assessment to their subscribers. (JA 1550, ¶ 9).

The New York State Insurance Department, recognizing that the cost of the 9% assessment was an expense that HMOs could not absorb, has granted rate increases that reflect the amount of the 9% assessment. (JA 1554, ¶¶ 24, 25; *see* Exhibit "B" annexed to R 32 [JA 16]). For example, Oxford Health Plans was awarded a 2.6% increase for the last three months of 1992 "to reflect the 9% inpatient hospital surcharge it currently pays." (Exhibit "B" annexed to R 32 [JA 16]).

The District Court Decision

Respondents moved for summary judgment in the district court on the grounds that the 11% and 13% surcharges are preempted by the Federal Employees Health Benefits Act ("FEHBA") and that the 9%, 11% and 13% surcharges are preempted by ERISA. Petitioners cross-moved for summary judgment to dismiss the complaints.

By Opinion and Order dated February 3, 1993, Judge Louis J. Freeh held, *inter alia*, that all of the surcharges related to employee benefit plans and were preempted by ERISA. Rejecting the Second Circuit's then out-dated analysis in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), Judge Freeh held that the surcharges were preempted by ERISA because they imposed a substantial economic burden on employee benefit plans that was likely to affect the structure and/or administration of the plans. Specifically, Judge Freeh stated that the 9% assessment will force HMOs to transfer the cost of the assessment, via an increase in rates, to employee benefit plans. (A-71). Judge Freeh also noted that, in many cases, the assessment could result in a 2.5%-3.5% increase in the rates charged to subscribers. (A-71-72, nn. 6-7).

Significantly, Judge Freeh recognized that the additional revenue generated by the assessment is not applied to any use even remotely related to the health care of plan participants. (A-74). Thus, to the extent that the assessment diverts plan resources by directing that they be paid to the State, it has a substantial impact on ERISA plans—costing plan sponsors and participants millions of dollars annually.

Judge Freeh also held that the surcharges were not preserved by the insurance savings clause, which exempts from preemption laws regulating the business of insurance. As to the 9% assessment, the court held that it "could not possibly fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law." (A-79).

The Second Circuit Decision

On January 14, 1994, the United States Court of Appeals for the Second Circuit issued an amended opinion affirming Judge Freeh's decision that ERISA preempted all of the challenged surcharges.[5] The court held that the surcharges were sufficiently "connected with" employee benefit plans to justify preemption. Noting that the 9% assessment interfered with an ERISA plan's selection of the most effective way to provide benefits, the court held that the surcharges purposely interfered with the choices that such plans make for health care coverage. Indeed, the court held that the surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits, thereby forcing ERISA plans "to increase either plan costs or reduce plan benefits." (A-23). Thus, the court held that the surcharges also have an impermissible impact on ERISA plan structure and administration. (A-24).

The court expressly declined to follow the Third Circuit's decision in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), on the grounds that it improperly relied on *Rebaldo v. Cuomo* and too narrowly interpreted ERISA's preemption provision.

Expressly adopting the district court's holding that HMOs are not, as a matter of law, insurance companies, the court also rejected the claim that any of the surcharges were preserved by the insurance savings clause.

[5]The amended opinion supplemented the court's earlier opinion by holding that the 11% and 13% surcharges were also preempted by FEHBA.

On March 7, 1994, the Second Circuit denied the motion of the Blues and HANYS that the court rehear the ERISA preemption issue *in banc*.

REASONS FOR DENYING THE WRIT

I. There is no Conflict Between the Circuits as to Preemption of A State Law that Increases an Employee Benefit Plan's Cost of HMO Health Care Coverage if the HMO is Unable to Enroll a Certain Number of Medicaid Recipients

Regardless of any conflict that petitioners claim exists between the Second Circuit's decision regarding the 11% and 13% surcharges and the Third Circuit's decision in *United Wire*, there is no conflict regarding the 9% assessment.

Petitioners do not deny that the 9% assessment has affected employee benefit plans. They do not dispute that the 9% assessment has caused, and will continue to cause, HMOs to increase the rates charged to their subscribers. Nor do they deny that these increases will be substantial. They also do not dispute that most HMO contracts are with employee benefit plans. Instead, they rely primarily on the Third Circuit's decision in *United Wire*, which involved a hospital rate statute far different from the one at issue here, to support their claim that the 9% assessment is not preempted by ERISA and that a conflict between the circuits exists.

The statute at issue in *United Wire* (the "New Jersey statute") concerned the rates actually charged by hospitals

for certain procedures and the discounts given by the hospitals to particular categories of payors. The New Jersey statute prospectively set hospital rates on the basis of DRGs and required hospitals to include in the DRG rate a charge to cover bad debt expenses and the cost of uncompensated care provided to the indigent. The New Jersey statute also provided DRG discounts to high volume plans and plans with open enrollment. At the same time, the New Jersey statute authorized hospitals to charge patients who did not belong to such plans an increased rate to allow hospitals to recover the income lost by virtue of the discounts.

In contrast, the 9% assessment has nothing to do with hospital rate reimbursement. The purposes of the 9% assessment are to compel HMOs to enroll Medicaid recipients and to raise revenue for the State. The statute attempts to accomplish this goal by imposing a penalty, calculated at 9% of its aggregate hospitalization cost, on HMOs that fail to comply with the State's Medicaid objectives. That the 9% assessment is connected to the cost of hospitalization is purely arbitrary. The legislature could have selected any other fixed or variable yardstick to determine the amount to be paid by HMOs that were unable to comply with the State's Medicaid objectives.

Thus, the 9% assessment differs in many critical respects from the hospital reimbursement scheme challenged in *United Wire*. First, unlike the *United Wire* surcharge which is added to the patient's hospital bill and is kept by the hospital, the 9% assessment does not increase the actual rate that HMOs pay hospitals. Rather, it is a separate charge that is imposed by the State on HMOs that fail to enroll a target number of Medicaid recipients. As such, the 9% assessment

has no effect on the rate an HMO pays a hospital for the cost of services provided to its subscribers. Second, unlike the surcharges at issue in *United Wire* that were specifically designed to reimburse hospitals for bad debts and uncompensated care, the 9% assessment does not function as a tool to reimburse hospitals. Indeed, the assessment produces no revenue whatsoever for the hospitals. Third, unlike payments made directly to hospitals pursuant to the New Jersey statute, the 9% assessment is paid by the HMOs into a statewide pool and deposited directly into the State's General Fund. Thus, the hospitals neither receive the funds nor act as a conduit for their transfer to the State. Lastly, unlike the *United Wire* payment scheme, the 9% assessment does not regulate the cost of hospital care. Indeed, the primary purpose of the 9% assessment is to encourage HMOs to enroll Medicaid patients.[6]

Thus, the petitioners' efforts to construct a conflict between the Third Circuit's decision in *United Wire* and the Second Circuit's decision in this case fall apart when applied to the 9% assessment. There simply is no conflict and, accordingly, no reason for this Court to grant certiorari on the question of whether the 9% assessment is preempted by ERISA.

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[6]Even if the statutes here were identical, there would not be a conflict requiring review. *United Wire* relied principally on the Second Circuit's decision in *Rebaldo v. Cuomo*, whose analysis has now been discredited by subsequent decisions of the Supreme Court and the Second Circuit. *See infra* at 20-22. Indeed, the Third Circuit appears to be retreating from its own decision. *See Travitz v. Northeast Department ILGWU Health and Welfare Fund*, 13 F.3d 704, 710 (3d Cir. 1994) (court declined to follow *United Wire* distinguishing the facts of that case from the one before it).

II. The Issues Presented by the 9% Assessment are Neither Matters of National Importance Nor Likely to Recur

The Second Circuit's decision preempting the 9% assessment will have no substantive effect beyond the confines of this particular case. The 9% assessment is nothing more than a narrowly tailored attempt by New York State to encourage HMOs to enroll Medicaid recipients by imposing a penalty on those that fail to achieve certain Medicaid targets. It does not regulate the cost of hospital care, nor does the money generated by it ever flow through the hospital system. Indeed, there are no cases currently pending that involve a similar assessment, nor have there been any reported decisions on the issue. Moreover, New York appears to be the only state with such an assessment.[7]

Petitioners nonetheless regale the Court with a "sky is falling" argument that all hospital and health care regulation throughout the nation will come to an immediate halt if the Second Circuit's decision that the 9% assessment and other surcharges are preempted is allowed to stand. Even if petitioners' arguments as to the 11% and 13% surcharges were correct, they are inapplicable to the 9% assessment. The 9% assessment does not regulate either the cost of hospital care or the cost of goods used by hospitals. As such, its preemption will have no effect whatsoever on the ability of New York, or any other state, to regulate the operation of hospitals and the cost of hospital care.[8]

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[7]Although the State asserts that at least 22 other states have health care regulations similar to "one or more of the disputed surcharges" (State Petition at 14), it does not point to any state with a penalty like the one imposed here.

[8]Indeed, none of the many cases cited by petitioners which purport to involve similar hospital reimbursement schemes involve anything like the 9% assessment at issue in this case.

Similarly, the Second Circuit's decision preempting the 9% assessment will not impede federal cost containment policies or the ability of states to enact comprehensive all-payor hospital cost containment legislation. (*See* HANYS Petition at 18). As previously discussed, the 9% assessment is tied to the cost of hospitalization only because of an arbitrary decision by the State to use that mechanism as a way to impose a penalty on HMOs that do not enroll the target number of Medicaid recipients. Neither the imposition nor the collection of the penalty itself is related to the cost of hospitalization in any substantive fashion. Indeed, if the 9% assessment was removed entirely from New York's hospital rate regulation scheme, there would be no effect on hospitals.

Lastly, the decision of the lower court that the 9% assessment is preempted by ERISA is simply not ripe for review at this juncture. As noted by the State, the nation is on the verge of health care reform (*see* State Petition at 16). As part of the legislative process, Congress will have every opportunity to revise or amend the scope of ERISA's preemption provision if it so chooses. Thus, the pendency of national health care reform argues in favor of this Court deferring review of the Second Circuit's 9%-preemption decision.[9]

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[9]Moreover, at the request of petitioners New York State and HANYS, Congress enacted legislation that would cause businesses to lose their ability to deduct the cost of their health care coverage if their insurer, or HMO, does not reimburse hospitals in accordance with New York State's hospital reimbursement scheme. Section 13442 of the Omnibus Budget Reconciliation Act of 1993, 26 U.S.C. § 162(n). Thus, contrary to petitioners' claims, a decision to deny certiorari will have little immediate impact on hospitals or the State.

III. The Second Circuit Correctly Held That The 9% Assessment is Preempted by ERISA

A. The 9% Assessment Relates to Employee Benefit Plans

The Second Circuit correctly interpreted governing Supreme Court precedent, which emphasizes the broad nature of ERISA's preemptive sweep, in concluding that the 9% assessment is preempted by ERISA. As noted by the Second Circuit and as this Court has long emphasized, a law relates to an employee benefit plan for the purposes of preemption if "it has a connection with or reference to such a plan". *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 583 (1992). Under the "broad common-sense meaning" attributed to this phrase by the Supreme Court, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987), "a state law may 'relate to' a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans or the effect is only indirect." *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 139 (1990).

Despite the Supreme Court's broad interpretation of ERISA's preemptive reach, petitioners nonetheless assert that the Second Circuit wrongly concluded that the 9% assessment does not sufficiently "relate to" an employee benefit plan to warrant preemption. Petitioners fail to acknowledge, however, that the economic impact experienced by the HMOs is not merely an incidental or indirect cost of doing business. In essence, the cost of the 9% assessment had to be large enough to persuade the HMOs that it was not economically feasible to refuse to enroll the desired number of Medicaid patients. Thus, Judge Freeh found that the effect was intended to be and was in fact substantial. (A-73).

The HMOs submitted substantial evidence of this impact, which was relied on by the District Court and the Second Circuit in arriving at their conclusion that the economic impact of the 9% assessment on employee benefit plans was substantial. For example, in the 1993-1994 fiscal year, the 9% assessment was intended to raise approximately $30 million from HMOs and the employee benefit plans they serve. (JA 1733). Thus, HMOs were required to pay millions of dollars to the State. The HMOs themselves simply cannot absorb this cost. (JA 1554, ¶ 23). Because the reserves maintained by HMOs cannot be used to defray administrative expenses like the 9% assessment, HMOs have no choice but to pass the cost of the assessment on to the ERISA plans.

Faced with the threat of increased fees and/or reduced benefits, an ERISA plan cannot, as suggested by petitioner HANYS (*see* HANYS Petition at 20-21), merely switch to an alternative health insurance system. HMOs do not simply reimburse independent providers of care; HMOs provide access to care. Accordingly, an ERISA plan cannot select alternative coverage without, in many cases, disrupting the care that is being provided to its employees. Nor can employee benefit plans simply opt to avoid the assessment by eliminating HMOs as a health care option. *See* N.Y. Pub. Health Law § 4403 (McKinney 1985); N.Y. Comp. Codes R. & Regs. tit. 10, § 98.15 (1992) (employers with more than 25 employees must offer HMOs as a health care option).

Moreover, because the 9% assessment forces ERISA plans to either pay increased plan costs to provide the same level of benefits or reduce plan benefits to offset the cost of the assessment, the Second Circuit correctly found that the

9% assessment sufficiently "interfere[d] with the choices that ERISA plans make for health care coverage" as to constitute a "connection with" ERISA plans. (A-22-23). The assessment thus imposes precisely the kind of burden on plan administration that ERISA was designed to avoid. For example, the Second Circuit relied on *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991), in which a state statute imposing a 2.5% tax on administrative and service fees was preempted by ERISA. In *E-Systems*, the Fifth Circuit held that

> The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation.

E-Systems, Inc., 929 F.2d at 1103. *See also General Electric Co. v. New York State Dep't of Labor*, 891 F.2d 25, 28 (2d Cir. 1989) (provision of New York labor law which required particular employers to pay employees certain benefits was preempted by ERISA because "private parties, not the Government, control the level of benefits" under ERISA) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 [1981]), *cert. denied*, 496 U.S. 912 (1990).[10]

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[10]The case at hand is very different from *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), relied on by petitioners. In *Mackey*, the Supreme Court based its decision that a state law permitting the garnishment of welfare benefits was not preempted by ERISA on the presence of a separate provision in ERISA which expressly forbid garnishment of a participant's *pension* benefits, rather than on an analysis of the statute's economic impact on the plan. The Court held that once Congress was aware that ERISA plan benefits could be attached or garnished, its decision to remain silent regarding *welfare* plan benefits "acknowledged and accepted the practice, rather than prohibiting it." 486 U.S. at 837 (quoting *Alessi*, 451 U.S. at 516).

In addition, although not raised by petitioners, it is important to note that the 9% assessment cannot function irrespective of ERISA plans. As a general matter, the Second Circuit noted that eighty-eight percent of non-elderly Americans receive some form of private health care coverage through ERISA plans. (A-6). The vast majority of the HMOs' subscribers are beneficiaries of ERISA plans.

Further evidence that ERISA was intended to preempt surcharges such as the 9% is found in President Clinton's proposed Health Security Plan. In that plan, the President expressly provides that the new plan will *modify* ERISA's current preemption provision to, *inter alia*, permit states more flexibility in regulating health care. White House Domestic Policy Council, Working Group Draft (September 7, 1993), *reprinted in The President's Health Security Plan—The Complete Draft Report of the White House Domestic Policy Council* 80 (Times Books) (1993). Had the President and his health care council believed that such laws were not already preempted by ERISA, no such modification provision would have been necessary.

B. The Second Circuit Was Correct in Refusing to Follow *United Wire* and *Rebaldo*

The Second Circuit also properly rejected petitioners' reliance on *United Wire* and *Rebaldo*. As noted by the Second Circuit, the principle that to be preempted a state law must "purport to regulate" an ERISA plan, emanating from *Rebaldo v. Cuomo*, has now been expressly rejected by the Supreme Court. (A-21).[11] Because the *United Wire* deci-

[11]In *Rebaldo*, the Second Circuit held that regulations governing the right of self-insured employee benefit plans to negotiate discounts with hospitals was not preempted by ERISA because the law did not purport to regulate the terms and conditions of employee benefit plans. *Rebaldo*, 749 F.2d at 137.

sion relied heavily on *Rebaldo* and too narrowly interpreted ERISA's preemption clause, the Second Circuit declined to follow it.

In 1990, the Supreme Court issued two decisions which establish that in order to be preempted by ERISA, a state law need not make express reference to nor purport to regulate an ERISA plan. In the first, *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), this Court held that its earlier ERISA preemption decision of *Shaw v. Delta Air Lines*, 463 U.S. 85, 95 (1983), which held that a law related to an employee welfare plan and is preempted by ERISA if it has "a connection with or reference to such a plan," was not intended to mean that only those state laws "specifically designed to affect employee benefit plans" or concerning the subject matter covered by ERISA, are preempted by ERISA. Indeed, the Supreme Court further elaborated on this issue a short time later in its decision in *Ingersoll-Rand v. McClendon*. In *Ingersoll-Rand*, the Court held that a law relates to a benefit plan for preemption purposes "even if the law is not specifically designed to affect such plans, or the effect is only indirect." 498 U.S. at 139.

Following those decisions, the Second Circuit shifted gears and held that "a state law of general application, with only an indirect effect on a pension plan, may nevertheless be considered to 'relate to' that plan for preemption purposes." *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 (2d Cir. 1992). In the District Court's decision here, Judge Freeh adopted this analysis and concluded that the 9% assessment is preempted by ERISA. (A-69, 75).

The Second Circuit here correctly adopted Judge Freeh's determination that *Rebaldo*'s fundamental premise, rejected by the Supreme Court (and later Second Circuit precedent), poisoned that decision's entire analysis. (A-21). Thus, the

Second Circuit properly held that petitioners' reliance on *Rebaldo* was misplaced and refused to follow the decision of *United Wire* which relied on it. The Second Circuit held instead that the surcharges satisfied the less stringent "connection with" standard of *Ingersoll-Rand*. (A-22).[12]

[12]There is no reason for this Court to review the Second Circuit's decision that the 9% assessment is not saved from preemption by the insurance savings clause. First, petitioners did not argue below and do not appear to be arguing here that the 9% assessment is saved from preemption. Second, and most importantly, the 9% assessment is directed solely at HMOs. As the Second Circuit held, New York law does not require HMOs to be state-licensed insurers. N.Y. Ins. Law § 1109(a) (McKinney 1985 & Supp. 1993). Nor can HMOs include in their names "words generally regarded as descriptive of the insurance function." N.Y. Public Health Law § 4411 (McKinney 1985). Thus, the court correctly held that the 9% assessment does not fall within the scope of the savings clause because HMOs do not engage in the business of insurance. (A-26-27 n.5).

Conclusion

For the foregoing reasons, the petitions for a writ of certiorari should be denied.

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Respectfully submitted,

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